A Process Evaluation of the Newcomer Women's Health Clinic

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Abstract: The Newcomer Women's Health Clinic (NWHC) was opened in 2014 to bridge a gap in services for newcomer women to Canada residing in Metro Vancouver. Since opening, the NWHC has been underutilized, operating at 50% capacity. A process evaluation was conducted to understand clinic utilization and what potential barriers exist for newcomer women accessing health services. Evaluation data was collected via patient intake forms (N=107), patient feedback surveys (N=31), and one to one interviews with newcomer women (N=7) and with service providers who work with newcomer women (N=8). Quantitative data from intake forms and surveys provided an overview of the sociodemographic characteristics of patients, while qualitative data from open-ended survey questions and interviews provided more nuanced insight into barriers that may contribute to the underutilization of the clinic. Overall, newcomer women and service providers consider the clinic a valuable service, but lack of knowledge and promotion of the NWHC arose as a common theme in surveys and interviews. Additional themes identified through interviews include language and location barriers, differing perspectives of health and health seeking behaviours, difficulty navigating health systems and services, and social isolation and social networks. With approximately 40,000 newcomer women immigrating to BC from out of country every year, the NWHC has the potential to meet a substantial need and provide health services to a population commonly experiencing individual, social, and structural barriers to health. Recommendations are provided to help improve the delivery of services and contribute to a rich and ongoing dialogue concerning the diversity of experiences of newcomer women in Canada.

Introduction

The population of newcomer women in Canada is a broad and diverse group who share the common experience of having recently relocated to a new country. Though the circumstances under which this experience takes place and the social and system supports available to each woman may vary significantly (e.g. based on immigration status, familiarity with new location, migrating independently or with one's family, migrating to flee violence or war), newcomer women arriving and settling in Canada have repeatedly been found by academic researchers to experience difficulties accessing health services (Asanin & Wilson, 2008; Hynie, Crooks, & Barragan, 2011).

In 2012 in British Columbia, newcomer women's health was established as a priority by the Ministry of Health and Ministry of Jobs, Tourism, and Skills Training in an effort to facilitate successful integration and settlement of newcomers in BC (BC Centre of Excellence for Women's Health, 2014). However, a subsequent environmental scan revealed a lack of health services available to newcomer women in the Metro Vancouver Region of British Columbia (BC Centre of Excellence for Women's Health, 2014). To fill this gap in services, the Newcomer Women's Health Clinic (NWHC) was established at the BC Women's Hospital and Health Centre.

Although the NWHC has been functional since August 2014, it has been underutilized; as of July 2015 it was booking appointments at approximately 50% capacity. In order to better understand the low uptake of services provided by the NWHC, a process evaluation was conducted. The objective of the evaluation was to assess experiences of newcomer women currently accessing the clinic as well as to gain a better understanding of potential barriers which may contribute to underutilization. This paper will present and discuss evaluation findings and

offer recommendations to improve delivery and accessibility of health services through the NWHC.

Background

Newcomer Women's Health in Canada

Newcomer women have been repeatedly identified in the literature as a population facing many barriers to health and health services. Key challenges identified include language barriers (Campbell, Klei, Hodges, Fisman, & Kitto, 2014; Crooks, Hynie, Killian, Giesbrecht, & Castleden, 2011; Higginbottom et al., 2015; Merry, Gagnon, Kalim, & Bouris, 2011; Newbold, Cho, & McKeary, 2013), lack of knowledge of health services (Crooks et al., 2011; Higginbottom et al., 2015; Merry et al., 2011; Newbold et al., 2013), difficulties finding a primary care provider (Asanin & Wilson, 2008; Newbold et al., 2013), financial constraints (Asanin & Wilson, 2008; Crooks et al., 2011; Newbold et al., 2013), transportation or location issues (Asanin & Wilson, 2008; Crooks et al., 2011; Newbold et al., 2013), and lack of cultural sensitivity of health care services or staff (Asanin & Wilson, 2008; Crooks et al., 2011; Donnelly et al., 2011; Higginbottom, Hadziabdic, Yohani, & Paton, 2013). All of the studies cited above identified barriers by engaging directly with newcomer women and other key stakeholders using qualitative methods including surveys, interviews or focus groups.

While some of the aforementioned studies focused quite exclusively on experiences of newcomer women accessing health services, many of the studies also recognized a broader struggle with inequities at a macro level. For example, Merry and colleagues identify social determinants including income, housing, and social support as potential underlying contributors to health inequities in newcomer women (Merry et al., 2011). In addition, Higginbottom and colleagues explore the marginalization of the needs and rights of newcomer women in their

families, communities, and in legislation, and Newbold and colleagues note the general absence of voices of refugee and refugee claimant women from scholarly literature and policy formation (Newbold et al., 2013).

Given the well-established evidence highlighting barriers to access as well as more macro level challenges, newcomer women inevitability experience health inequities. What's more, inequities can lead to or be further exacerbated by increased experiences of social isolation and mental health issues following immigration (Crooks et al., 2011; Donnelly et al., 2011; Hynie et al., 2011). As a result, many newcomer women seeking to access health services may encounter care that is not sensitive to their needs, whether in terms of language, culture, finances, or other factors, or they may be unable to access care altogether, thus preventing them from maintaining physical and mental health and wellbeing.

Experiences of health inequity faced by newcomer women represent a significant issue for a country like Canada in which newcomers constitute approximately two thirds of the total population growth since 2003 (Edge & Newbold, 2013). In British Columbia, more specifically, approximately 40,000 newcomer women have immigrated from out of country every year since 2001 (BC Stats, 2015). As Higginbottom and colleagues argue, seeking equity for newcomer women is an established priority for Canada as "the Canadian Charter of Rights and Freedoms not only affirms the multicultural nature of Canadian society but arguably also mandates equity in healthcare access and health outcomes for all Canadians, regardless of their place of birth" (Higginbottom et al., 2015, p. 2).

The Newcomer Women's Health Clinic

In 2012, the Ministry of Health and Ministry of Jobs, Tourism, and Skills Training identified newcomer women's health as a priority for ensuring successful integration and settlement of newcomers in British Columbia (BC Centre of Excellence for Women's Health, 2014). At this time, the BC Centre of Excellence for Women's Health was contracted to complete an environmental scan of health services available to newcomer women across the province. The scan found only one health service in the Metro Vancouver Region tailored specifically for newcomer women – the BC Women's New Beginnings Maternity Clinic (BC Centre of Excellence for Women's Health, 2014). The scan also identified two programs specifically serving immigrant men and women, however, these services had strict eligibility criteria such that only refugees could access services. Furthermore, though a number of additional health services advertise language translation – seemingly accommodating the needs of newcomer women and others facing language barriers – the accompanying webpages often lacked clear details regarding how to access services, which languages were offered, and whether or not there was an associated cost (BC Centre of Excellence for Women's Health, 2014).

In response to the barriers identified in the literature as well as the dearth of active services geared specifically towards newcomer women across the Metro Vancouver region, the Newcomer Women's Health Clinic was established in 2014 at the BC Women's Hospital and Health Centre in an effort to fill a gap in services. The NWHC took over a space previously occupied by the Asian Women's Health Clinic, which had provided women's health screening through Pap tests or breast exams to Asian women – a population that had been identified in the literature as having low preventative screening levels (BC Women's Hospital & Health Centre, 2012). The transition from the Asian Women's Health Clinic to the Newcomer Women's Health

Clinic was initiated by hospital management in order to reach a larger population of women in need of health services.

The NWHC offers primary health care services to newcomer women age 18 years and older who have lived in Canada less than 5 years and do not have a primary healthcare provider. Primary care services are provided by a nurse practitioner and include, but are not limited to: Pap tests, cervical cancer screening, breast cancer screening, testing for sexually transmitted infections, contraceptive counseling and family planning, and care for respiratory problems, pain, and cold or flu. Medical interpreters from the Provincial Language Services are available for appointments at no cost to the patient. Women may attend the clinic for a single visit or multiple visits for up to two years after which clinic staff support them in transitioning to primary care providers within their communities. The clinic operated 2 days a week from 9am to 4pm when it was first opened, but due to slow uptake of services, it is now open only 1 day a week with the exact schedule determined by availability of the nurse practitioner and clinic space.

Given the health inequities and barriers to access experienced by newcomer women in Canada reported in the literature, the underutilization of the NWHC – a service seeking to specifically address newcomer women's needs – is unexpected and even appears incongruent. By collecting information related to the activity of the clinic, the evaluation aims to review and contextualize findings within the broader discussion of newcomer women's health in Canada in order to better understand reasons for underutilization and generate recommendations for how services may be improved.

Methodological Framework

In drawing upon feminist principles, the evaluation team agreed that there are multiple ways of knowing, and some ways of knowing are privileged over others (Seigart, 2005). By using a mixed methods approach for this evaluation, the project team aimed not only to review the activity of the clinic since its opening, but to incorporate experiences and feedback from the largest number of patients possible given the small budget and one year timeline of the evaluation. In providing newcomer women, an often marginalized population, the space to express their opinions through surveys and one-to-one interviews, the team sought to subvert a hierarchy of privilege and include these voices as a prominent part of the evaluation. This emphasis of voice stems from traditions of feminist, ethnographic, and post-modern research in which the perspectives and experiences of marginalized populations are prioritized so that they can make visible that which is important to them (Coyle & Williams, 2000; Guruge & Khanlou, 2004). Furthermore, using a range of data collection methods allowed the comparison and corroboration of results from various sources.

It is also important to note that the evaluation team recognizes the role of intersectionality in newcomer women's experiences as these individuals have the potential to face barriers via multiple social identities and locations in addition to immigration status. Intersectionality recognizes that experiences of health are located within a complex web of contexts including dimensions at the individual level like race, gender, and class, as well as within broader socio-economic, historical, and political contexts (Guruge & Khanlou, 2004). With this in mind, the present evaluation did not aim to essentialize a "newcomer experience" to which the NWHC should be tailored. Rather, this project seeks to acknowledge the immense diversity that exists within this population, examining both inter- and intragroup differences (Newbold et al., 2013),

and use the collected data to improve the clinic's capacity to provide a safe and supportive service that mitigates commonly experienced barriers among newcomer women.

Methods

A process evaluation was determined to be most appropriate to evaluate the NWHC as it is a type of evaluation specifically intended for active programs or projects, and the clinic has been functional since August 2014. Process evaluations aim to thoroughly review an implemented program to determine effectiveness and impact, positive and/or negative, in order to promote accountability and encourage continued development and improvement (World Health Organization, 2000).The main questions the evaluation seeks to answer include:

1) Who is currently accessing services through the NWHC?

2) Are clinic services valuable to the patients who access them?

3) What are reasons behind why newcomer women have not used the clinic?

In order to explore these questions, the evaluation team determined to collect and analyze data using a mixed methods approach gathering information using patient intake forms, a patient feedback survey, and one-to-one semi-structured interviews with newcomer women and with service providers who work with newcomer women.

All patient intake forms were filled out at first contact with new patients by one of the clinic clerks. The intake forms allowed for the collection of important background information of women visiting the clinic. Information gathered using this method included the total number of women who had visited the clinic since its opening as well as background sociodemographc information including age, neighbourhood of residence, primary language, whether an interpreter

was requested, and whether the patient had MSP or other health insurance coverage. This information served as a foundation upon which to build in-depth profiles of experience using the following, more involved evaluation methods.

Surveys were distributed by clinic clerks to all patients of the NWHC upon arrival at scheduled appointments, and patients were asked to complete the survey (about 5-7 minutes long) and return it to one of the clerks. Surveys included both closed- and open-ended questions and were collected from July 2015, when the survey was developed, until March 2016. The survey served a similar purpose to the review of patient intake forms in that it allowed the continued collection of more detailed background information to determine the social characteristics and circumstances of women visiting the clinic. In addition to background information, the survey also asked patients questions related to experiences with clinic services and quality of care received.

Semi-structured interviews with service providers and newcomer women were conducted to better understand experiences of newcomer women seeking to access health services in Metro Vancouver. All interviews were facilitated by myself on site at BC Women's Health Centre or at an alternate location within the community based on the individual's availability and preferred location. The semi-structured interview format offered flexibility in the direction of the conversation such that it proposed a small number of general inquiries related to the topic of interest, but allowed for emergent themes and ideas to arise based on each individual's unique experience and perspective.

Recruitment of service providers was based on a purposive sampling approach and involved reaching out to individuals in Metro Vancouver who had experience working with newcomer women and with whom the NWHC Program Manager had previously connected

during professional events such as conferences, forums, community meetings, or in other similar settings. Service providers were contacted via phone or email and invited to participate in a key informant interview in support of the NWHC evaluation. Questions posed to service providers focused on the process by which service providers refer newcomer women to different social and health services as well as any barriers they have encountered during this process and how they may have been able to overcome barriers. Service providers were also asked about their familiarity with the NWHC and whether or not they had referred any women to the clinic. During recruitment, a total of 9 service providers were invited to participate. Eight service providers responded to the invitation to participate and were interviewed. All interviews were audio-recorded, and field notes were taken simultaneously. The interviews lasted between 20-70 minutes.

Newcomer women were recruited using two different methods of purposive sampling. Women who were patients at the NWHC received a consent to contact form in the same package as the patient feedback survey distributed by clinic clerks. The forms invited women to provide contact information if they wished to receive further details about participating in an interview for the NWHC evaluation. Patients who returned this form were contacted directly. All patients were assured that their identity would remain confidential, and that agreeing or declining to participate in the evaluation interview would not affect their care at the NWHC in any way. Newcomer women who had not used the NWHC were also recruited. These women learned of the evaluation and received project team contact information through settlement service providers who had participated in the service provider interviews.

Interviews with newcomer women focused on experiences of health and accessing health services both before and after coming to Canada. Women were specifically asked if they had

faced any difficulties in seeking services. Similar to the service provider interviews, newcomer women were also asked about their familiarity with the NWHC. For those who had visited the clinic as a patient, they were asked to provide feedback about their experience. A total of 7 semi-structured interviews were conducted with newcomer women. Two of the women were patients of the NWHC while the remaining 5 were referred by service providers. All interviews were audio-recorded, and field notes were taken simultaneously. Each interview lasted between 15-30 minutes long. Newcomer women were given a small honorarium of $30 for their participation.

Though the evaluation collected sensitive information from human participants, it was exempt from Research Ethics Review in compliance with the 2nd edition of the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2 2014).* Article 2.5 in the *TCPS2 2014* indicates that program evaluation activities used exclusively for improvement purposes, such as in the case of the NWHC evaluation, do not fall within the scope of REB review. In lieu of ethics, a Privacy Impact Assessment was submitted and approved by the Information Access and Privacy Department at BC Women's Hospital and Health Centre.

Results

Patient Intake Forms

From the opening of the clinic in August 2014 to March 2016, the NWHC saw a total of 107 new patients who were eligible for services. Patients resided in a range of neighbourhoods across and beyond Metro Vancouver with most patients (60.7%) living in Vancouver, less than 10% of patients living in each of New Westminster, Surrey, and Burnaby, and less than 5% living in each of Richmond, Coquitlam, North Vancouver, West Vancouver, Chilliwack, White Rock, and Maple Ridge. The average age of patients visiting the clinic was 33.7 years with the youngest patient at 20 years and the oldest at 61 years. At least 16 different primary languages

were represented among clinic patients, and approximately 30% of patients used interpreter services provided by Provincial Language Services. Close to half of the patients visiting the clinic had MSP coverage while the other half had no MSP coverage. Though not all patient intake forms provided detail about length of time in Canada other than to confirm that the patient met the clinic criteria of less than 5 years, at least 35.5% of patients had only lived in Canada for less than 1 year.

The patient intake form also collected responses to the question "Where did you hear about the NWHC?" but unfortunately data was not collected consistently (N=48 no response). For the remaining patients for whom a response was collected (N=59), 40.7% had found out about the clinic through an online search, 35.6% were referred by providers of settlement, social or other health services in the community, 13.6% were referred by other clinics and health services within BC Women's Hospital and Health Centre, and 10.2% found out about the clinic through a friend or family member.

Table 1. Patient Intake Form

	Total
# Patients using services	107
Age distribution (years)	
Mean	33.7
Median	32
Minimum	20
Maximum	61
Neighbourhood of residence	
Vancouver	60.7%
New Westminster	9.3%
Burnaby	8.4%
Surrey	7.5%
Other (7)	14.1%

Primary language spoken	
English	35.5%
Spanish	26.2%
Mandarin	9.3%
Russian	5.6%
Other (12)	23.4%
Interpreter requested	
Yes	29.9%
No	67.3%
No response	2.8%
MSP or other health coverage	
Yes	49.5%
No	50.5%
How did you hear about the NWHC?	
Online	22.4%
Settlement services	19.6%
BC Women's Hospital and Health Centre	7.5%
Friend/family member	5.6%
No response	44.9%

Patient Feedback Surveys

A total of 31 patients who visited the clinic from July 2015 to March 2016 completed and returned the patient feedback survey. Within this subpopulation of patients, 20 different countries of origin were identified, and women relocated to Canada with a range of immigration statuses. The highest proportion of women (29%) listed their status as temporary foreign worker or in possession of a work visa, 25.8% identified as landed immigrants, 19.4% had no status (undocumented), 9.7% each held a student visa or claimed refugee status, and one individual (3.2%) identified as a refugee claimant. The average age of patients completing the survey matched the average age of the total patient population almost exactly at 33 years, and most women (38.7%) reported the reason for their visit was to get a Pap test. Other reasons for visits included experiencing pain, vaginal problems, or inquiring about contraception. The majority of women were married (61.3%), and most did not have any children (67.7%). In coming to their

appointments, most women took public transit (62.3%), while 19.4% drove and 12.9% walked. Among women who filled out the survey, at least 9 different languages were represented with the highest proportion of women (38.7%) listing Spanish as their primary language. The second highest proportion of women identified English as their primary language (29%).

When asked why they did not have a primary care provider, one of the eligibility criteria for the clinic, 41.9% of women responded that they did not have health insurance, 25.8% said they could not find a provider accepting new patients, and 12.9% said they worried about privacy and confidentiality. Other reasons cited – with less than 10% of women responding positively to each – included: could not find a female provider, could not find child care, nervous or afraid, long wait times at a doctor's office or clinic, and could not find a provider that speaks the same language.

The survey also collected responses about patients' experiences during their NWHC appointment and the quality of care they received. Inquiring about patients' interactions with the nurse practitioner, 100% of patients strongly agreed with each of the statements: "The nurse practitioner understood my health concerns," "The nurse practitioner took my health concerns seriously," and "I felt respected by the nurse practitioner." When given the opportunity to provide comments, feedback was extremely positive. Patients described the nurse practitioner and staff of the clinic as "very friendly and super helpful" and "patient and 100% professional." One patient responded: "It's been the best experience when going to the clinic."

Approximately 97% of patients rated quality of care during their appointment at the NWHC as either excellent (87.1%) or very good (9.7%). The remaining individual (3.2%) rated care as good. The vast majority of patients also indicated that they would recommend a friend or family member to the NWHC with 97% responding positively and the remaining individual

(3.2%) responding “maybe”. When asked why they would or would not recommend someone they knew to the NWHC, women gave a range of positive responses including “The service is wonderful,” “Everybody is very friendly, I am very happy,” and “I felt well-treated and the staff was just amazing.” Some patients included comments acknowledging the value of services specifically for newcomer women. One woman commented: “They know how to give proper advice to women about their health and the health care system in Canada.” Another shared: “It’s really helpful for people who are new in Canada who don’t know where they should go when something happen to them.” A third woman stated: “It is a very helpful resource for people who have not been in Canada long enough to establish a relationship with a family doctor, and the care is very personal and professional, much more so than a lot of walk-in clinic.”

Finally, women were asked to provide comments or suggestions for the clinic. Only four patients opted to give feedback, but three of these four comments were related to increased promotion of the service. Patients shared their recommendations that NWHC staff should “Advertise more about the clinic” and that “Info about its existence should be more readily available.” The remaining comment suggested including a map at appointment booking as the patient found that the location of the NWHC within the hospital was confusing and hard to find.

Table 2. Patient Feedback Survey

	Total
# Patients completed and returned survey	31
Reason for visit	
Pap test	38.7%
Pain	16.1%
Contraception/Family planning	12.9%
Vaginal problems	9.7%
Other	22.6%
Communication with NP	
English	67.7%
Clinic interpreter	25.8%
Informal interpreter	6.5%

Quality of care received	
Excellent	87.1%
Very good	9.7%
Good	3.2%
Fair	0%
Poor	0%
Experience with Nurse Practitioner	
Agreed NP understood health concerns	100%
Agreed NP took health concerns seriously	100%
Agreed felt respected by NP	100%
Reasons for no regular health care provider	
Do not have health insurance	41.9%
Cannot find provider accepting new patients	25.8%
Worry about privacy and confidentiality	12.9%
Other	19.4%
Transportation to appointment	
Public transit	62.3%
Private car	19.4%
Walked	12.9%
Other	5.4%
Primary language	
Spanish	38.7%
English	29.0%
Farsi	16.1%
Other	16.1%
Age Distribution (years)	
Mean	33.0
Median	33
Minimum	21
Maximum	46
Time in Canada (months)	
Mean	17.2
Median	12
Min	1
Max	60
Status in Canada	
Temporary foreign worker/Work visa	29.0%
Landed immigrant	25.8%
No status	19.4%
Student visa	9.7%
Refugee	9.7%
Other	6.4%
Marital Status	
Married/Common-law	61.3%
Single	38.7%
Children	
No children	67.7%

1-2 children	22.6%
3-5 children	6.5%
No response	3.2%
Would you refer a friend/family member?	
Yes	96.8%
No	0%
Maybe	3.2%

Semi-structured interviews with newcomer women

Due to limitations in resources, transcription of the interview audio-recordings was not possible. Nevertheless, the audio-recordings were independently assessed by two reviewers (myself – the Evaluation Coordinator – and the NWHC Program Manager) and detailed notes were coded for broad themes. Upon completion of this process, the reviewers came together to share individual findings and identify themes that were common to both analyses.

It should be noted that even though only a small number of newcomer women participated in the interviews (N=7), the range of experiences represented in each of these conversations was incredibly diverse. The women involved in the interviews came from 5 different countries and while some had experienced extreme trauma both before and after coming to Canada – such as with one woman who fled a war-torn country only to be arrested upon arrival in Canada for having no immigration papers – others shared that their health was generally good and their experience with health services in Canada had been positive overall. Even with such diverse experiences, a number of prominent, recurring themes were identified, and these have been included below.

Challenges understanding and navigating the health system – The phrase of "I don't know where to go" came up multiple times throughout the interviews with newcomer women. Sometimes it was shared in the context of the woman having so many physical

and mental health concerns she did not know where to go to seek help, but it was also brought up in the context of confusion with the Canadian health care system and not knowing where to go depending on the type of care the woman desired to access (e.g. emergency care, routine appointments, specialist appointments). One woman shared her experience being a highly educated newcomer woman who had previously lived in another country with a "Western" health care system before arriving in Canada:

Even though I'm highly educated and I'm exposed to a western health system, even then I feel this hesitation and confusion, it's not, the information is not that easy and going to accessing information through internet or website, the health system, it's, I mean, it's not, I mean, applicable and easy to access…Even for me as an educated person with a health background has this barrier to access information, you can just imagine women coming from the third world and who has a language barrier, who don't know anything about the health system in the western country, and who has, I mean, limited education system. You can just imagine how would they access the system. So it's more difficult for them. So it's not easy.

Lack of knowledge of NWHC – Upon asking women about their previous knowledge of the NWHC, we learned that none of the newcomer women who had been referred through service providers had heard of the NWHC before being invited to participate in the evaluation. Moreover, one of the women who had accessed the NWHC previously shared that she did not think many other newcomer women were aware of its existence.

Differences in perceptions of health and health needs – During the interviews, the women spoke of health in somewhat different ways. For example, one woman stressed that in her country of origin, people do not generally seek out medical assistance unless they are

very sick. When asked about what kinds of health care services women felt they needed most right now, a couple of women indicated that they either did not have any immediate health needs or mentioned a health concern that had been bothering them lately, such as a sore knee. However, in other conversations, women spoke of wanting to find a health service in which they could access more regular check-ups or address less immediate health needs. One woman spoke of wanting somewhere to go for concerns related to aging, while another spoke of needing regular appointments for a chronic condition. A third woman mentioned the increasing importance of screening as she grew older.

Differences in health systems – Another important theme that arose throughout the interviews was related to differences that women noticed between the Canadian health system and the health system in their country of origin. For instance, some of the women had emigrated from countries in which there was a parallel public-private system for primary care. They shared that in these systems, anyone who had money would opt for private care since the quality of the care provided through the public systems was often quite poor. The differences of the Canadian system compared to what they were familiar with was often cited as a source of confusion. In addition, one woman indicated that compared to accessing private care in her country of origin, she was hesitant to make explicit requests of health care providers and express her opinions openly in Canada since she was not paying for the service up front. In contrast to paying for a private service in her country of origin, she felt as though she had less power as a patient in Canada.

Stress, anxiety, and fear – Though some of the women interviewed indicated that their health was and had been good before and after coming to Canada, there were a couple of women who expressed serious challenges dealing with trauma, anxiety, and fear implying

a need for mental health services. One woman spoke directly to this need stating: “I have so much problem, I don’t know where I should go to treat this problem I have, my mental health problem….I’m always tired, my mind is always busy thinking.” Other symptoms of concern that women shared included excessive crying, inability to sleep, and persistent migraines. In addition to being a newcomer to Canada, these women shared that they had come to Canada to flee violence or abuse, and some had struggled financially since their arrival.

Social isolation and social networks – Indirectly, in discussing the factors that contributed to women’s experiences seeking and accessing health services, social support networks were mentioned in a positive way when women had access to them. For example, one younger woman spoke of the support she received from her foster parents while settling in Canada as they provided assistance in various ways from finding a family doctor to helping navigate other health needs like dental care. However, this was not the case for all women. Others talked extensively about their loneliness and separation from family members who remained in their country of origin.

Wait times – The final theme that came up throughout the interviews was the experience of long wait times in the Canadian health care system. Particularly for women who were used to a private health care system in their country of origin, they expressed concerns over wait times not only to see certain providers such as specialists, but to obtain MSP coverage. Interviewees expressed frustration and even dissatisfaction when they had to wait months to access services or to book an appointment with a specialist.

Semi-structured interviews with service providers

There was a substantial amount of overlap in the themes of the service provider interviews compared to the newcomer women interviews. A total of 8 interviews were conducted with various service providers in and around Metro Vancouver. Most individuals were associated with settlement service agencies, but two service providers worked for other agencies providing health services more directly. In addition, the populations of newcomer women that service providers worked with was diverse. For instance, one provider worked mostly with refugees and refugee claimants, another worked with a more senior population, and other providers had greater experience working with newcomers with a more precarious immigration status. Prominent themes that arose during the interviews are identified below.

Challenges navigating the health system – In addition to newcomer women expressing confusion in navigating the Canadian health care system, service providers also addressed this issue as a barrier for accessing health services. One service provider shared that one of the ways their organization was seeking to overcome this barrier was by inviting different service providers into their space to connect with newcomers rather than referring clients out. Others talked about holding workshops as a way to demystify the navigation of the health care system and to provide support for complicated processes such as applying for a health card or finding a family doctor.

Need for NWHC promotion – Even though all of the service providers had been familiar with the NWHC through professional interactions with the Program Manager, some service providers expressed concern that there did not seem to be widespread awareness of the clinic and its services among newcomer populations. More extensive promotion of the NWHC was suggested a couple times throughout the interviews, not only to increase

awareness among newcomer women, but among other service providers to continue to build networks of support.

Perceptions of health – During the interviews, one service provider spoke of differences in newcomer women's perceptions of health referring to cultural differences and varying knowledge of prevention and understanding of mental health. However, the more prominent discussion among other providers seemed to be about different perceptions of health as a priority. For the service providers who had worked more extensively with women who had fewer social and material supports following immigration, they talked about how basic needs such as finding housing or food or legalizing one's status in Canada would take priority over most health-related concerns requiring assistance from a health care professional. Thus, they shared that their focus in providing support to newcomer women was often to ensure that these more basic needs were met before moving onto health-related tasks such as scheduling doctors' appointments.

Stress, anxiety, and fear – Discussions of stress, anxiety, and fear faced by newcomer women arose in different contexts during the interviews. While some service providers spoke of the fear surrounding new experiences, others spoke of anxiety and other mental health issues following the stress of traumatic experiences before or after immigration and the need to address and support women through these issues. Moreover, entering a hospital setting, where the NWHC is situated, and giving out private information were described as fear-invoking for women with a precarious immigration status – whether undocumented or waiting on immigration papers to be processed. Service providers shared that it was not uncommon for women to fear that their immigration status or jobs would be at risk if health care providers identified more serious medical needs.

Social isolation and social networks – Experiences of social isolation among newcomers came up often as a topic of discussion throughout the service provider interviews. Many providers spoke of the opportunity that newcomer service providers have to help build social networks among newcomers by offering group-based services. Group care was seen as a way not only to facilitate social connections, but more practically, providers saw opportunities for group education and counselling to have additional benefits for newcomer women. With group-based services, a diverse group of newcomer women could help promote richer dialogue and women may also find comfort in sharing their experiences and relating to others who may have similar stories.

Language barriers – Nearly all service providers discussed language, even if only briefly, as a barrier for newcomer women's health. There seemed to be a general consensus among providers that non-English speaking newcomers faced some of the greatest challenges in accessing services. Even with interpreter services available, as they are at the NWHC, providers indicated that challenges remained since this service adds another degree of separation, and there is potential for tensions to exist between the newcomer client and interpreter, cultural or otherwise.

Location barriers – As mentioned above in the theme of stress, anxiety, and fear, the hospital setting in which the clinic runs was perceived by many service providers to be a barrier for newcomer women, especially for women with a precarious immigration status. Furthermore, others shared concerns that the physical location of the clinic, both within the hospital and within the city, may be difficult for many newcomers to access. The vast majority of service providers shared that in their experience, newcomers are moving further away from Vancouver proper and settling instead in the surrounding areas of

Burnaby, Surrey, Coquitlam, New Westminster, and other less central locations. Thus, a clinic in the middle of Vancouver was not seen to be readily accessible to newcomers.

Family-oriented services – Another barrier to accessing care for newcomer women that came up during the interviews was the limitations of a women-only service such as the NWHC. Many providers talked about how a number of the clients they worked with had families, and mothers were often more concerned about the needs of their children than their own. To find someone to take care of their children in order to access a service such as the NWHC was seen as an added challenge. Furthermore, the service providers who worked in organizations providing health services indicated that their own strategies included seeing families together, or at least having the space for families to bring their children or relatives with them for appointments. Offering more family-oriented services was seen to improve convenience of accessing care and helped make women feel more comfortable visiting a new and unfamiliar place.

Continuum of Care – The final theme that came up in a number of service provider interviews was the need for more holistic, integrated, and continuous services for newcomer women. Providers talked about how in the current system, many of the different service components needed to facilitate settlement, such as immigration, housing, employment, and health, are separated. Some shared their thoughts about the importance of building a network among providers so that services would be easier to navigate for newcomer women.

Discussion

The findings of this evaluation bring forward a number of important points of discussion related to the Newcomer Women's Health Clinic as well as newcomer women's health in

Canada more broadly. While data collected from the patient intake forms, patient feedback survey, and two of the newcomer women interviews focus on the demographics, needs, and experiences of women who have visited the NWHC as a patient, the remaining interviews provide insight into the experiences of newcomer women who are eligible to access the NWHC but have not yet utilized its services. This discussion will draw together findings from each data collection source to understand similarities and differences between the needs and experiences of both patients and non-users of the NWHC in the Metro Vancouver region. This information, in turn, will provide insight into which populations of newcomer women may continue to face barriers in accessing health services and help determine future directions and strategies to increase utilization of the NWHC.

Based on results from the patient feedback survey, the vast majority of patients accessing the NWHC gave positive feedback and reported that they had received a high quality of care during their visit. A number of service providers also shared that they felt the NWHC provided a necessary and valuable service. However, lack of awareness of the service and a need for increased promotion came up repeatedly in discussions with service providers, users and non-users of the clinic. The patient intake forms provided one point of insight into effectiveness of current promotion strategies as it asked new patients how they had heard of the NWHC. Even though there was a high number of missing responses for this question (44.9%), the responses that were collected reveal certain promotion efforts that have resulted in new users. The collected responses (N=59) indicated that internet searches (40.7%) and referrals from providers of settlement, social or other health services in the community (35.6%) were the primary channels of promotion bringing in new patients during the data collection period. Moreover, in taking a closer look at the community referrals for new patients, a range of different organizations had

referred women to the NWHC, but there were two organizations in particular that had repeatedly referred clients - the Umbrella Multicultural Health Cooperative and Sanctuary Health. Both of these organizations had been consulted during the planning phase of the NWHC. These referrals may also explain the higher proportion of Spanish speakers among the NWHC patient population as these organizations work with a high number of Spanish speaking women, though this relies on some speculation because as mentioned above, referral source was not consistently collected.

Though this evidence suggests effectiveness of an online presence and community referrals in bringing in new patients, these strategies are clearly not sufficient to maximize the clinic's capacity. Given that online promotion is not accessible to newcomer women who are computer illiterate or do not have access to the internet, as well as there are many other settlement agencies in Metro Vancouver not currently referring any newcomer clients, it is important to increase promotion with alternative strategies. Additional strategies for promotion outside of these methods will be explored in the recommendations below.

Another important finding supported by data from each of the various collection sources is that NWHC patients as a population represent a wide diversity of sociodemographic characteristics and experiences by age, country of origin, language skills, status in Canada, family composition, support systems, health needs, perceptions of health, and a number of other factors. At the same time, there are trends in the data as collected through the patient intake forms worth exploring as they offer insight into certain social factors and experiences that may function as either lower or higher barriers to access for newcomer women seeking health services.

First, the patient intake forms indicated that most newcomer women using the NWHC reside in Vancouver proper. This finding makes sense logically as women living in the city are in

closer proximity to the physical location of the clinic. However, as discussed in the findings above, during the interviews a number of service providers shared their perceptions that newcomers are settling farther away from the city hub with many newcomers ending up in places like Surrey, Burnaby, Coquitlam, and New Westminster. Results showed that the remain 39.3% of women not from Vancouver proper are travelling to the clinic from these surrounding areas, with a couple of patients travelling even further from places such as Chilliwack and White Rock. Given these results, it is possible that there are more newcomer women in the areas surrounding Vancouver who would benefit from services, but may face barriers in accessing the NWHC due to its distance from their place of residence. Alternatively, it is also possible that women in these areas may be willing to travel the distance, similar to the current NWHC patients from these areas, but living further away from the clinic may limit their awareness of the clinic's existence altogether.

In terms of family structure, the patient feedback survey revealed that patients visiting the clinic are fairly young on average (33 years), and the majority of patients do not have children (67.7%). In comparing this information to the interview data, many service providers reported that the majority of their own clients had families and they considered a women-focused clinic, like the NWHC, as a possible barrier to care. It is possible that these findings are reflective of a higher number of young newcomer women without children settling in closer areas surrounding the clinic. However, the lower percentage of mothers seen at the clinic may also indicate, as service providers implied, higher barriers and lower accessibility for this population such that women with children may have difficulty securing childcare in order to visit the NWHC on their own. In order to clarify the causes underlying this patient population trend, more research involving newcomer women with children is required.

In reviewing the themes related to barriers that came up through the semi-structured interviews, both newcomer women and service providers shared a number of challenges faced by newcomer women in seeking to access health services that overlapped with findings in the literature cited above. The interviews revealed that while some of the challenges faced may be more unique to newcomer women, such as with language barriers, differences in health systems, and stress, anxiety, or isolation related to settling in a new country, other barriers faced, such as wait times or challenges navigating the health system, are also common among permanent residents and citizens of Canada. Regardless of whether barriers faced are unique to the newcomer population or not, it is important to address as many of these barriers as clinic resources allow.

In addition to barriers to access, another point of discussion that arose in the interviews as seen in the themes related to "stress, anxiety, and fear" and "social isolation" is the impact of settlement on newcomer women's mental health. Though there were newcomer women participating in the interviews who seemed to have strong systems of support throughout their settlement process by way of tight-knit families or social networks, others experienced trauma, abuse, and other hardships leading to increased stress and anxiety. In addition to newcomer women expressing personal experiences of mental health issues, service providers also indicated the importance of supporting and increasing these services.

One other finding from the patient intake forms worth addressing is that approximately half of all patients visiting the NWHC (50.5%) do not have MSP coverage at the time of their first appointment. This is an important statistic to address as it has the potential to affect sustainability of the clinic as well as bring about ethical dilemmas. There are multiple possible explanations behind this lack of MSP coverage for patients. For instance, these patients may be

very new to Canada and either they have not yet applied for MSP coverage or they may still be undergoing the waiting period for coverage forms to be processed. Alternatively, patients may be accessing the clinic while on tourist visas and therefore not require MSP coverage, or they may be undocumented in Canada. Whatever the reasons behind the lack of MSP coverage, the high percentage of patients without MSP implicates important needs of the current patient population in regards to accessing services such as treatments and more specialized diagnostic procedures that fall outside of the scope of NWHC services. Without MSP coverage, patients may be left in precarious financial situations if more serious health concerns are uncovered that extend beyond the capacity of the NWHC and their only option for access is to pay out of pocket. Some informal partnerships have been established to facilitate access to services outside of the clinic where possible, but there are still financial risks that may be incurred by patients. This issue has been recognized among NWHC staff and administration and discussions are ongoing in terms of seeking supportive solutions.

Limitations

Though this evaluation contributes valuable information to the discussion of newcomer women's health in Canada, a number of limitations exist. First, during the development of the data collection instruments, particularly the patient feedback survey and the semi-structured interviews, all questions were put forward by the evaluation team. Given that women who filled out the surveys and participated in the interviews had varying levels of English fluency, it is possible that despite best efforts to phrase questions in plain language and use the support of a translator if one was booked for the appointment, some of the questions may have been confusing or difficult to understand and thus may not have been answered accurately. For the surveys in particular, it would have been preferable to distribute translated copies for patients

with a different primary language and limited English fluency, but limited time and funding did not allow this strategy.

Another possible limitation that may have affected the data collected, particularly when women were asked to provide feedback on their experiences within the clinic, is a social desirability bias. Even though surveys were anonymous and women who participated in interviews were assured that anything they shared would remain confidential and the care they received at the clinic would not be affected by their responses in any way, there may have still been a degree of fear or hesitation in expressing any negative thoughts or critiques related to clinic services.

In addition to the above limitations, due to restrictions in time and resources, only a small number of newcomer women participated in interviews, and patient feedback surveys were only filled out by a portion of the total patient population (29.0%). With these small numbers, it is highly likely that there are a number of newcomer women accessing or qualifying for NWHC services whose experiences are not represented in this report. For example, all newcomer women who participated in the interviews had at least a conversational fluency in English. Though I had access to interpreter services to conduct interviews with women who were not fluent in English, we were unable to recruit any non-English speaking newcomer women. Thus, the perspectives of non-English speaking newcomer women were not represented in the interviews.

Language is just one example of potential exclusions that may have occurred throughout the evaluation as the data collected showed the population of newcomer women in the Metro Vancouver area to be an incredibly diverse group. It is possible that the information collected through this evaluation more accurately represents the needs and experiences of select populations of newcomer women over others based on any number of intersecting factors such as

age, ethnic background, family structure, education, profession, religion and other social locations and experiences.

It would be impossible to represent the experiences of all newcomer women in Metro Vancouver within this evaluation, and we openly acknowledge this limitation, but the goal of the evaluation was never to generalize a "newcomer woman's experience". Rather, the goal was to better understand the diversity of the NWHC patient population and other newcomer women eligible to access NWHC services in order to provide direction for future ways in which the NWHC may overcome barriers to access and increase capacity. While the information presented here does not provide anywhere close to a comprehensive understanding of the issues at hand, the limitation of a small sample size does not take away from the validity of the data presented. The interviews and surveys captured a wide range of experiences and the data collected through these methods will surely help guide important future directions for the NWHC to make it a safer, and more accessible service for newcomer women in Metro Vancouver.

Recommendations

As the NWHC is still at a relatively formative stage in its existence, there are many possible routes that could be taken at this point in time to continue to grow and expand services. The first, and arguably most practical recommendation is for clinic management to engage in increased promotional activities to spread awareness of the existence of the clinic. The issue of a lack of awareness of the NWHC was brought up multiple times throughout the evaluation by both newcomer women and service providers, but compared to other barriers that arose in discussion, it represents a less nuanced barrier that may be addressed more easily than others. As described in the discussion above, an online presence and connecting with community organizations serving newcomers are two strategies of promotion that have already been

effective in bringing in new patients. In line with these findings, NWHC management could continue to partner with different service providers and community organizations working with newcomers to increase awareness of the clinic and gain more referrals. In addition, as service providers participating in interviews repeatedly addressed language as a barrier for newcomer women seeking care, it would likely be useful to distribute translated promotional materials. NWHC management could partner with community organizations to determine which languages would be most appropriate.

In terms of service expansion and future directions of the clinic, strategies that were put forward and supported during the service provider and newcomer interviews included considering alternative delivery locations for services, expanding services to be more family-oriented, and providing more flexible clinic hours such as through evening hours. Many service providers communicated that newcomers are settling further away from the city core into surrounding areas, and as such it is more difficult for them to access services within Vancouver. The NWHC may consider partnering with service providers or community organizations in other areas of Metro Vancouver to find feasible alternative locations for delivery and provide a more convenient location for newcomer women living outside of Vancouver proper.

Moreover, by expanding services to be more family-oriented, the NWHC can overcome potential barriers for newcomer women who may not feel comfortable visiting the clinic on their own or for newcomer women with children who cannot secure child care. This may be facilitated by providing an option for scheduling back-to-back appointments for patients who would feel more comfortable visiting the clinic with a friend or family member. In addition, clinic management may explore options of partnering with BC Children's Hospital to expand a

newcomer clinic for children and youth so that newcomer women may address the needs of both themselves and their children.

A final way in which clinic management may consider expanding services of the NWHC would be to offer counselling or other mental health services. Through the interviews, it became apparent that the experience of immigrating to a new country can be extremely stressful and challenging. While mental health services would not be necessary for all patients attending the NWHC, there are women who meet clinic criteria who would benefit greatly from this type of added support.

Critical Reflection

Completing this capstone has been a challenging and time-consuming process, but it has been extremely rewarding and valuable for my growth and learning as a public health practitioner. One of my main points of learning throughout this process that I came back to time and again was the importance of engaging in reflexivity and interrogating my own assumptions. As I personally lack the lived experience of the common factor of the population I sought to work with and support, I constantly had to check that I was not inserting my own logical reasoning into the conversation. Instead, I made a conscious effort to always harken back to the data to verify that my interpretations of the evaluation findings were supported by the experiences of newcomer women and service providers working with newcomer women as they shared through the different data collection methods.

Furthermore, I acknowledge that the project involved an extensive amount of learning as I progressed. From the planning of the evaluation framework during my practicum to writing up the evaluation report, I experienced a few key shifts in my own perspective, specifically in regards to the evaluation methodology. Though the specific types of data collection methods did

not change drastically, I gained a broader understanding of the nature of intersectionality and adopted more of an intersectional lens during the data collection and analysis phases of the project. This lens had a significant impact on the way I viewed the data being collected and allowed me to truly wrap my head around the limitations this data carried with it. Intersectionality helped me to understand more fully the vast differences in terms of needs and circumstances among the population of newcomer women I sought to engage with, as well as it brought me face to face with the immense challenge of drawing together any summary statistics or conclusions from such a diverse population. However, in various conversations with supervisors, professors, and classmates, I came to recognize that simply speaking to these limitations and acknowledging the role of my own perspective and biases as well as those of other stakeholders in the collection of evaluation results is a critical piece of the work itself. As such, I was able to move forward with the work understanding that it would be limited, but hopeful that it would reflect important needs of at least a portion of the newcomer women I had engaged with and bring about meaningful recommendations through that.

In addition to engaging in reflexive practice through interrogating assumptions and adopting more of an intersectional lens as the evaluation proceeded, I also came to greatly value the collaborative atmosphere at BC Women's Hospital and Health Centre and the space my supervisors and mentors created to explore ideas in dialogue. By engaging in critical conversations with the Program Manager of the NWHC as well as with other staff, I am confident that this report was more rigorous and thoughtful than it would have been had I gone into this process on my own.

Overall, I am proud of the work I have accomplished through this evaluation, despite its limitations. Through this opportunity, I have been able to build valuable skills and develop an

important document that I hope can be used to enhance health equity for a population often facing barriers to access to care. I am extremely grateful for the brilliant, thoughtful, and encouraging individuals I have had supporting me along the way as I know this project would not have been possible without their help and guidance.

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